International Planned Parenthood Federation

IMAP Statement on Safe Abortion

Key points:

• When performed early in pregnancy by trained health personnel in adequate facilities, abortion is a very safe procedure
• Counselling should always be available to help a woman decide whether or not to continue her pregnancy, but should never be imposed on her
• Women seeking abortion should be given full information on the methods, including what to expect during and after an abortion
• Selection of the method depends on the duration of pregnancy, the training and skill of the provider, the facilities available, and the preference of the woman
• Vacuum aspiration, electric or manual, is the surgical method of choice for abortion up to 12 weeks since last menstrual period
• Early medical abortion (up to 9 weeks), with a combination of mifepristone and a prostaglandin, is effective and safe.
• Post-abortion care, including counselling and family planning services, should be offered promptly in all cases.

Introduction

Induced abortion is a common procedure throughout the world. Of more than 45 million procedures performed each year; at least half occur in unsafe circumstances. These unsafe abortions carry a high risk of maternal mortality and morbidity, accounting for almost 80 000 maternal deaths each year. Restrictive abortion legislation does not substantially reduce the overall number of abortions but greatly increases the proportion that are performed unsafely.

Since the decision to seek an abortion usually results from an unwanted pregnancy, expanded and improved family planning services should be the highest priority to prevent such pregnancies and decrease recourse to abortion.
In circumstances where abortion is not against the law, health service providers should be trained and equipped to offer a safe and accessible service. Provision of, or referral for, abortion services is an essential part of women’s sexual and reproductive healthcare: fulfilment of a woman’s right to choice should be a high priority for such
programmes. As with all sexual and reproductive health services, the client’s right to confidentiality and privacy must be sustained.

When performed in early pregnancy by well-trained practitioners in adequate facilities, abortion has an excellent safety record. Beyond 10 weeks since last menstrual period the health risks rise with each week of pregnancy. Thus, efforts should be made to inform the public that abortion is safest when performed early, and women who seek abortion should be encouraged to attend as early in the pregnancy as possible. Services should ensure there is minimum delay in the provision of abortion. Since the skill of the provider is fundamental to safe abortion, health personnel who offer abortion services must be properly trained. Those who work in services providing only early abortions must know about the facilities to which they can safely refer clients whose pregnancies are of longer duration.

**Counselling and information**

Many women will have decided firmly, before coming to the health service, that their pregnancy should be terminated. Some, however, will be uncertain whether or not to have an abortion and be troubled by anxiety or guilt; adolescents, in particular, may lack support from partners or family. Although counselling must never be imposed, every woman contemplating abortion should have access to supportive empathetic counselling, responsive to her personal circumstances and cultural background. Such counselling should include the different options open to her and the opportunities for assistance that exist in society. Even with counselling some women require extra time to come to a decision.

In some circumstances a woman may be under pressure from her partner, her family, or other members of society to have an abortion or to continue the pregnancy. Unmarried adolescents may be particularly vulnerable to such pressure. If coercion is suspected, this possibility should be discussed in private with the woman.

Women who may have been victims of sexual abuse should be referred for any other care they need.

When medical abortion is contemplated, the client should be informed about the drug regimens and the amount of bleeding and pain to be expected. Women who request surgical abortion should be fully informed about the procedures to be performed, including the medication for pain management and the types of anaesthesia available, what to expect during and after the procedure, and how long it will take. The safety of the procedures and their possible immediate and late side-effects and complications should be discussed. The woman should be given contraceptive counselling, both before abortion and at any follow-up visits.

The time of an abortion is not usually an ideal moment for a woman to make a major decision such as whether to be sterilised. However, where a woman will have difficulty
returning later for the procedure, sterilisation by minilaparotomy or laparoscopy can be safely combined with the abortion.

Pre-abortion care

The general health of the woman should be evaluated to detect any medical conditions that might increase the risk of an abortion procedure. When a serious medical condition exists, the abortion should be performed in a specialised facility where any risk can be reduced to the minimum and complications can be properly treated. Women should be screened for anaemia and their rhesus status should be determined if anti-D gammaglobulin is available for prophylactic use.

Pelvic examination must be performed to establish the duration of the pregnancy and to identify possible ectopic pregnancy, concurrent infection, or uterine abnormalities. The presence of sexually transmitted infection (STI) increases the risk of post-abortion pelvic infection. Routine prophylactic prescription of antibiotics for women undergoing abortion is not essential, but should be considered for women who are at high risk of STI or who come from communities with a high background prevalence of STI. Where infection is clinically present or identified by screening, antibiotics should be started before the abortion is performed.

Abortion techniques

The chosen method for inducing abortion will depend on the duration of the pregnancy, the training and skill of the provider, the facilities available, and the preference of the woman. In most cases the gestation can be determined reliably from the date of the last menstrual period and the findings on pelvic examination. Ultrasound investigation is necessary only when there is clinical doubt about the period of gestation or suspicion of
ectopic pregnancy. Unless the woman has a serious pre-existing medical condition or the chosen method requires an inpatient stay, both surgical and medical abortion should be done as outpatient procedures. Figure 1 illustrates the appropriate methods in relation to gestation.

**Surgical methods**

**Vacuum aspiration**

Vacuum aspiration is the preferred surgical method up to 12 weeks since last menstrual period, and some skilled practitioners can do it safely up to 15 weeks. The contents of the uterus are evacuated through a plastic or metal cannula attached to a vacuum source. The vacuum can be generated either by an electric pump or with a hand-held plastic 60 mL syringe.

Abortion after 6 weeks requires a paracervical block or light sedation or both. General anaesthesia increases the risk of the procedure and should be avoided except possibly for some late abortions. Before 6 weeks, aspiration can be done without cervical dilatation. From 6 to 9 weeks cervical dilatation may be needed and after 9 weeks it is usually required. This can be done with mechanical dilators or with osmotic hydrophilic dilators such as laminaria tents. A prostaglandin such as misoprostol and/or mifepristone can also be used to prepare the cervix.

It is advisable to examine the aspirated materials to ensure they contain products of conception, and follow-up is recommended to exclude the possibility of continued pregnancy, either uterine or ectopic.

**Dilatation and curettage**

Dilatation and curettage (D&C) is applicable for abortion up to 12 weeks, although specially skilled providers can do it up to 14 weeks. D&C should be used only where vacuum aspiration or a medical method is not available, since sharp curettage carries higher risks. Health service managers should make every effort to replace sharp curettage with vacuum aspiration.

**Dilatation and evacuation**

Dilatation and evacuation (D & E) is the preferred surgical method for pregnancies of more than 12 weeks. However, it does require special skills and should be performed only in facilities where providers have a high enough caseload to maintain their expertise.

**Other methods**

The intra-amniotic or extra-amniotic instillation of various solutions is less safe and less effective than D & E and should be discouraged. Abdominal or vaginal hysterotomy is
very seldom indicated for late abortion. Hysterectomy should be used only for women with a condition that would warrant the operation independently.

**Medical Methods**

Pregnancy can be terminated medically with a combination of the antiprogestogen mifepristone and a prostaglandin such as misoprostol. Early medical abortion (up to 9 weeks) is very effective and safe. From 9 to 14 weeks, surgical abortion is at present recommended since the efficacy of medical abortion with current dosage regimens is lower, blood loss is greater, and products of conception are more likely to be retained. Beyond 14 weeks, when the placenta tends to be completely expelled, medical methods of inducing abortion offer a safe and effective alternative to surgical procedures. Less than 5% of women undergoing medical abortion will require surgical intervention for continuing pregnancy or incomplete abortion. Services that offer medical abortion should have access to facilities for surgical intervention.

Both early and late medical abortions involve the administration of mifepristone followed, after a variable interval (up to 48 hours), by a prostaglandin. After 14 weeks the prostaglandin usually needs to be given more than once.

An alternative to the prostaglandin/antiprogestogen combination after 14 weeks is the prostaglandin analogue misoprostol alone, although this seems less effective, slower to act, more painful, and more prone to gastrointestinal side-effects. Treatment regimens with misoprostol up to 14 weeks are under investigation because of the wide availability and low cost of this agent. In view of concerns about teratogenicity, women who use misoprostol to induce abortion should be warned that, if it fails, abortion should be completed surgically.

The combination of methotrexate with a prostaglandin is not recommended since it is less effective than mifepristone/prostaglandin, the procedure is slow, and again there is concern about teratogenicity.

**Post-abortion care**

Post-abortion care, especially counselling and family planning services, should be offered promptly and is recommended after all abortions, both medical and surgical. The post-abortion period is an opportunity to provide emotional support to women who need it and to re-emphasise contraceptive use. Women should be informed that they are capable of conceiving again immediately after an abortion. Where no medical contraindications exist, contraception can be started immediately after abortion. The diaphragm and cervical cap should not be used until 6 weeks after late abortion, and intrauterine devices are more likely to be expelled if inserted at the time of a late abortion. Post-abortion advice should include subjects of practical concern to women. There is no reason for a woman not to bathe or use tampons immediately after an abortion.
Ultrasound or pregnancy testing may be helpful to confirm clinical suspicion of ongoing pregnancy but should not be performed routinely.

Complications

Complications of early abortion include haemorrhage, infection, incomplete evacuation, cervical lacerations, uterine perforations, and thromboembolism. These complications, rare in early abortion, arise with greater frequency in late abortion. To these must be added anaesthetic complications.

Late sequelae

There is no evidence that having an uncomplicated abortion has any bearing on future fertility or causes adverse outcomes in subsequent pregnancies. The preponderance of evidence does not suggest an increased risk of breast cancer after induced abortion.

This Statement was developed by the International Medical Advisory Panel (IMAP) in October 1983; was adopted by the Central Council in November 1983; and amended by IMAP in 1992 and 1996. The Statement was last revised and updated by IMAP at its meeting in Tokyo in May 2001. IMAP reserves the right to amend this Statement in the light of further developments in this field.